

EMERGENCY INFORMATION ON STAFF

To be completed and placed on file prior to employment

NAME _____

ADDRESS _____

NAME OF DOCTOR _____ PHONE _____

HOSPITAL PREFERENCE _____ PHONE _____

NAME OF DENTIST _____ PHONE _____

To avoid any adverse drug reaction during an emergency, please list medications you are taking: _____

ALLERGIES _____

BLOOD TYPE (if known) _____

LIST OPERATIONS/HOSPITALIZATIONS WITHIN THE PAST YEAR _____

LIST CHRONIC MEDICAL PROBLEMS REQUIRING A DOCTOR'S CARE _____

EMERGENCY CONTACT PERSONS

NAME _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____